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AUTHORIZATION FOR DISCLOSURE AND/OR USE OF HEALTH INFORMATION

Health Information:

Patient Name: _____

Date of Birth: _____

Telephone Number: _____

City of Long Beach Facility Name: _____

Authorization for Disclosure and/or Use of Information:

I voluntarily authorize and direct the City of Long Beach to disclose and/or use my health information during the term of this Authorization to the recipient that I have identified below.

Recipient of Information:

To: _____
Recipient Name (Person or Organization authorized to receive and use the information)

Recipient Address: _____

_____

Recipient Telephone Number: _____

Purpose:

I understand that the specific purpose(s) of requested use or disclosure in this Authorization is(are) (initial the appropriate spaces and include other information where indicated):

_____ **(Initial)** Initiated at the request of the Patient.

_____ **(Initial)** Sharing with other healthcare providers.

_____ **(Initial)** Other (please describe):

_____
_____
_____
_____

Information to be Disclosed and/or Used:

This Authorization permits the City of Long Beach to disclose and/or use the following information:

_____ **(Initial)** All of my health information that the City of Long Beach has in its possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, genetic testing, mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from other health care providers that the City of Long Beach may hold.

_____ **(Initial)** Treatment records.

_____ **(Initial)** Laboratory tests.

_____ **(Initial)** Radiology reports.

_____ (**Initial**) Only the following records or types of health information (please describe, including any dates):

_____
_____
_____
_____

_____ **(Initial) I <u>SPECIFICALLY AUTHORIZE</u>** the release of HIV/Aids test results or any other information in the custody of the City of Long Beach related thereto.

_____ **(Initial) I <u>SPECIFICALLY AUTHORIZE</u>** the release of all psychotherapy or other mental health records or information.

_____ **(Initial) I <u>SPECIFICALLY AUTHORIZE</u>** the release of all drug, alcohol or other controlled substance records or information.

_____(**Initial**) **I <u>DO NOT</u>** authorize the release of the following described medical records:

_____
_____
_____
_____

Notice of Rights and Other Information:

I understand the following:

1. I have a right to revoke this Authorization at any time. If I revoke this Authorization, I must do so in writing and deliver my written revocation to the Long Beach City Attorney's Office. My revocation will be effective upon receipt, but will not be effective to the extent the City of Long Beach, the Recipient or others have acted in reliance upon this Authorization.

2. Once information is disclosed pursuant to this Authorization, it could be re-disclosed by the Recipient and may no longer be protected by federal privacy and confidentiality law (HIPAA).

3. I have a right to receive a copy of this Authorization.

4. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this Authorization.

Expiration:

This Authorization will remain in effect until _____ [date]. After that date, you are no longer authorized to release any medical, dental, laboratory, or hospital records concerning me without further written authorization.

Signature:

_____ [Date]

_____ [Signature]
(Patient / Authorized Representative)

If signed by someone other than Patient, state your legal relationship to the Patient: _____

_____ [Print name]